DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-10

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 14, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.230, 42 CFR 441 Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 1.06 million
b. FFY 2001 $ 1.06 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A page 3
Attachment 3.1-B page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A page 3
Attachment 3.1-B page 3

10. SUBJECT OF AMENDMENT:
Addition of Chiropratic Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review delegated to Commissioner Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis Boyd

14. TITLE:
Commissioner Dept for Medicaid Services

15. DATE SUBMITTED:

16. RETURN TO:
Sharon Rodriguez
Policy Coordination Branch
Department for Medicaid Services
275 East Main Street 6F-A
Frankfort KY 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 21, 2000

18. DATE APPROVED:
November 13, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 14, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Crosser

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ Limitations*

☐ Not Provided.

c. Chiropractors' services.

☒ Provided: ☒ No limitations ☐ With Limitations

☐ Not Provided.

d. Other Practitioners' Services.

☒ Provided: Identified on attached sheet with description of limitations, if any.

☐ Not provided.

7. Home Health Services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S): ALL

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

☒ Provided: ☐ No limitations ☒ With limitations*

b. Optometrists' Services

☒ Provided: ☐ No limitations ☒ With limitations*

c. Chiropractors' Services

☒ Provided: ☒ No limitations ☐ With limitations*

d. Other Practitioners' Services

☒ Provided: ☐ No limitations ☐☒ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.